



## TEXAS DEPARTMENT OF INSURANCE

### Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)

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## MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

### GENERAL INFORMATION

**Requestor Name**

DOCTORS HOSPITAL AT RENAISSANCE

**MFDR Tracking Number**

M4-15-1627-01

**MFDR Date Received**

January 30, 2015

**Respondent Name**

TEXAS MUTUAL INSURANCE COMPANY

**Carrier's Austin Representative**

Box Number 54

### REQUESTOR'S POSITION SUMMARY

**Requestor's Position Summary:** "Doctors Hospital at Renaissance is kindly requesting that the above claim be reviewed for payment. Based on your denial for no authorization and network contract. On 10-13-14 our representative spoke to Robert N @ 888-252-5075 who informed us that services were authorized for 1 year from 09-02-14 thru 09-02-15. Attached you will find the authorization letter. Also never did he mention that our facility is not part of the network; however, we were never informed of such network. It is an unfair practice to penalize our facility for information that was withheld during the benefit verification process... requesting that our claim be reprocessed for payment."

**Amount in Dispute:** \$3,102.30

### RESPONDENT'S POSITION SUMMARY

**Respondent's Position Summary:** "Texas Mutual claim [claim #] is in the Texas Star Network. (Attachment) The requestor received out of network authorization to treat the claimant consistent with Section 1305.103 (e) of the Insurance Code. However, Texas Mutual has no record the requestor obtained network preauthorization for the outpatient surgery nor has the requestor provided evidence of preauthorization. Instead the requestor argues the out of network authorization was sufficient to proceed with the surgery. Texas Mutual does not agree. No payment is due."

**Response Submitted by:** Texas Mutual Insurance Company

### SUMMARY DISPUTED SERVICES

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Ordered
October 13, 2014 and October 14, 2014	Outpatient Facility Charges	\$3,102.30	\$0.00

### FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

**Background**

1. 28 Texas Administrative Code §133.307, sets out the procedures for resolving medical fee disputes.
2. 28 Texas Insurance Code Chapter 1305 applicable to Health Care Certified Networks.

3. The services in dispute were denied by the respondent with reason code(s)
  - Note – Authorization was obtained for the out of network provider but a separate pre authorization is required to be obtain for the surgical procedure
  - CAC 197 – Precertification/authorization/notification absent
  - 786 – Denied for lack of preauthorization or preauthorization denial in accordance with the network contract

### Issue

1. Did the requestor obtain approval from the certified network to treat the injured employee?
2. Did the requestor obtain preauthorization for the disputed facility charges?
3. Is this requestor entitled to reimbursement for the disputed services?

### Findings

1. The requestor filed this medical fee dispute to the Division asking for resolution pursuant to 28 Texas Administrative Code (TAC) §133.307 titled *MDR of Fee Disputes*. The authority of the Division of Workers' Compensation to resolve matters involving employees enrolled in a certified health care network, is limited to the conditions outlined in the applicable portions of the Texas Insurance Code (TIC), Chapter 1305 and limited application of Texas Labor Code statutes and rules, including 28 Texas Administrative Code §133.307.

Chapter §1305.006 outlines the insurance carrier's liability for out-of-network healthcare and states, "An insurance carrier that establishes or contracts with a network is liable for the following out-of-network health care that is provided to an injured employee:

- (1) emergency care;
- (2) health care provided to an injured employee who does not live within the service area of any network established by the insurance carrier or with which the insurance carrier has a contract; and
- (3) health care provided by an out-of-network provider pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section [1305.103](#).

Texas Insurance Code §1305.153 (c) provides "Out-of-network providers who provide care as described by Section 1305.006 shall be reimbursed as provided by the Texas Workers' Compensation Act and applicable rules of the commissioner of workers' compensation."

The Divisions medical fee dispute resolution section, may address disputes involving health care provided to an injured employee enrolled in an HCN, only if the out-of-network health care provider provided health care to an in network injured employee pursuant to a referral from the injured employee's treating doctor that has been approved by the network pursuant to Section [1305.103](#).

The services in dispute were denied/reduced with reduction code "Note – Authorization was obtained for the out of network provider but a separate pre authorization is required to be obtain for the surgical procedure." The requestor, therefore has the burden to prove that it obtained the appropriate approval from the certified healthcare network for the out-of-network care it provided. The requestor, submitted a copy of an "Out of Network Authorization to Treat Injured Worker Covered by the Texas Star Network" dated September 2, 2014 issued to Doctors Hospital at Renaissance.

The Division finds that the requestor has therefore, met the exception outlined in Chapter 1305.006(1). As a result, the disputed services are under the jurisdiction of the Division of Workers' Compensation and therefore, eligible for medical fee dispute resolution. The disputed services are reviewed pursuant to the applicable rules and guidelines, pursuant to Texas Insurance Code §1305.153(c).

2. 28 Texas Administrative Code §134.600 states in pertinent part, "(f) The requestor or injured employee shall request and obtain preauthorization from the insurance carrier prior to providing or receiving health care listed in subsection (p) of this section. Concurrent utilization review shall be requested prior to the conclusion of the specific number of treatments or period of time preauthorized and approval must be obtained prior to extending the health care listed in subsection (q) of this section. The request for preauthorization or concurrent utilization review shall be sent to the insurance carrier by telephone, facsimile, or electronic transmission and, include the...(8) facility name, and the facility's national provider identifier if the proposed health care is to be rendered in a facility; and (9) estimated date of proposed health care..."

The insurance carrier denied the disputed services with denial/reduction code “CAC 197 – Precertification/ authorization/ notification absent.”

The Division will now determine whether the disputed outpatient facility charges were preauthorization by the network prior to rendering the disputed service. Although a letter dated September 2, 2014 supports that the facility, Doctors Hospital at Renaissance received an out of network referral from the Certified Network to treat the injured employee, no documentation was found to support that the requestor received its own, preauthorization from the Certified Network for facility services rendered at its location. The Division concludes that the requestor did not receive preauthorization from the Certified Network to treat the injured employee. The requestor failed to prove in this case that the treatment rendered at Doctors Hospital at Renaissance was preauthorized by the Certified Network. As a result, the requestor is not entitled to reimbursement for the disputed services.

3. The Division finds that the requestor did not obtain preauthorization for the facility charges rendered at Doctors Hospital at Renaissance on October 13, 2014 and October 14, 2014. As a result, the requestor is entitled to \$0.00.

**Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution. This finding is based upon a review of all the evidence presented by the parties in this dispute. Even though not all the evidence was discussed, it was considered.

***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services

**Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Manager

\_\_\_\_\_  
April 7, 2017  
Date

***YOUR RIGHT TO APPEAL***

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).